PRACTICAL PEARL: Allergic Rhinitis

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| **INTRODUCTION** | • Allergic rhinitis (AR) occurs in 78% of asthma patients.<br>• AR is an IgE antibody-mediated, inflammatory disease.<br>• Symptoms: nasal congestion, rhinorrhea (anterior and posterior), sneezing and itching.<br>• Occurrence might be seasonal (pollen), perennial (indoor allergens) or episodic (intermittent allergen exposure). |
| **INITIAL EVALUATION AND MANAGEMENT BY PRIMARY CARE** | • Identify triggers by history, laboratory or skin testing.<br>• Initiate allergen avoidance.<br>• Start oral antihistamines alone as initial treatment.<br>• If symptoms are poorly controlled, stop oral antihistamine and start intranasal steroids (INCS).<br>• Long term INCS therapy requires monitoring of eye complications and linear growth.<br>• Adding an oral antihistamine to an INCS, even if symptoms are incompletely controlled, does not add clinical benefit.<br>• If poorly controlled with persistent use of INCS then add intranasal antihistamine (INAH).<br>• Clinicians should not offer LTRA (i.e. montelukast) as primary therapy; INCSs are more effective than LTRAs across the range of allergy sx. **https://www.ncbi.nlm.nih.gov** |
| **WHEN TO REFER** | • If AR persists or if AR is well controlled but asthma control is difficult to achieve. |
| **HOW TO REFER** | • (413) 794-KIDS<br>• Pediatric Pulmonology |
| **WHAT TO EXPECT FROM BAYSTATE CHILDREN'S HOSPITAL VISIT** | • We can assist in allergen identification and avoidance education.<br>• Assess lung function in asthmatics and assist in achieving control. |